WORLD HEALTH ORGANIZATION

TOBACCO ALERT

EDITORIAL

EXCERPTS FROM THE KEYNOTE ADDRESS BY DR HIROSHI NAKAJIMA, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION, AT THE NINTH WORLD CONFERENCE ON TOBACCO AND HEALTH

The tobacco epidemic is an epidemic like no other. It is impossible to blame a biological pathogen – a virus, bacillus or bacterium. And neither ignorance nor the surprise effect provides an explanation. This epidemic, or more correctly pandemic, is sustained only by the search for financial gain. It is all about money.

The world over, tobacco manufacturers and merchants put their own financial interests before the health and lives of the thousand million consumers to whom they sell their products. These tobacco products all contain nicotine. And in global terms nicotine is unquestionably the substance responsible for the most persistent and most widespread drug dependence, even ahead of alcohol, marijuana, heroin and cocaine.

But ***tobacco kills***. Every year it kills three million people. Three million per year means one death every 10 seconds. Half the victims die in the prime of life. If the epidemic continues at the present rate, within 30 or 40 years tobacco will be killing 10 million people each year. One death every three seconds ...

The widespread use of tobacco products has not come about by chance. Up to now the effective marketing policies of the tobacco industry have mainly been applied in Western Europe, North America and the South Pacific. The search for new markets is now driving the industry to expand its efforts to all other corners of the earth. And it is succeeding.

Many consumers in the traditional markets, alerted by our information campaigns, have become aware of the risks of smoking. They are expressing new requirements and conducting new monitoring. ***Now driven onto the defensive, the tobacco industry is attacking WHO and trying to counter our work by publicizing research aimed at discrediting the clinical observations and epidemiological conclusions that have been built up over decades by the international scientific community. The tobacco industry is redirecting its marketing strategy and now targeting women, children and the developing countries.***

In the developed countries, per capita cigarette consumption has fallen by 10% since 1970. In the developing countries it has gone up by 67% over the same period.

WHO estimates the number of cigarettes smoked each year in the world (including bidis) at over six million million. It also estimates that about 41% of men and 21% of women in the developed countries are smokers. In the developing countries 50% of men smoke, as against only 8% of women, but in many of these countries the prevalence of smoking is increasing among women.

Tobacco is a drug whose consumption is very expensive in the long run. Not just in human terms, but in financial terms as well. Even taking into account the short-term benefits from the tobacco industry, the net loss suffered each year by the world community because of smoking is estimated at two hun-

cont'd on page 11

IN THIS ISSUE

WHO TRIBUTE TO JAMES GRANT 2

NINTH WORLD CONFERENCE ON TOBACCO AND HEALTH 3–9

WHO/REGIONAL OFFICE FOR THE WESTERN PACIFIC 10

WHO/TOH PROGRAMME 12

WHO TRIBUTE TO JAMES GRANT

WHO PAYS TRIBUTE TO JAMES GRANT, FORMER EXECUTIVE DIRECTOR OF THE UNITED NATIONS CHILDREN'S FUND (UNICEF)

"... in memory of a great leader, our long-time friend and colleague."

Jim Grant was a man of action, of passion, and of boundless generosity.

He passed away after a long illness which he fought with the same determination that he used in fighting for the world's children and women.

On behalf of WHO, I would like to convey my deepest sympathy to Mrs Grant, to his whole family and to our UNICEF colleagues. I wish to express my deepest gratitude for the friendship Jim Grant extended to me personally and for his immense contribution to WHO and to our common mission within the United Nations.

Words alone will not do justice to Jim Grant's life, his ceaseless struggle against poverty, indifference and injustice, his fifty years of dedication to international service, his fifteen years of passionate commitment to the children of the world, their survival, their well-being and happiness. The best and only worthy tribute we can pay Jim Grant's life and memory is humbly to continue his work, to try to follow in his footsteps and to remain true to his example, to the spirit in which he himself always lived and worked.

BUILDING A TOBACCO-FREE WORLD

James Grant:

It is a great pleasure for me to have the opportunity to address an issue that we at UNICEF consider to be of critical importance in this decade of the 1990s: smoking and children, in the context of the urgent need to promote healthy lifestyles and self-health as part of efforts to attain the international target of Health for All by the year 2000 and to achieve the goals for children adopted at the historic World Summit for Children in September 1990.

I come before you to applaud and support your crusade to build a tobacco-free world and to join my voice with yours in protest against those who would defend the practice of smoking tobacco on any conceivable grounds.

As industrial and developing countries alike search for new paradigms for financing health systems that effectively ensure coverage of *all* people, increasing emphasis is being given to *prevention* of ill health and to the role that individuals and families must play in preserving their own health, vitality, and productivity. The logic of this trend is impeccable.

This simple prescription for vastly improving people's health used to apply mainly to the rich countries, where chronic diseases – the so-called diseases of affluence – account for the bulk of premature deaths and illness. But today, numerous countries of the developing world are making the demographic-epidemiological transition, leaving them with the double burden of transmissible and chronic disease – without having attained the affluence that would help them ease the burden.

Whenever we talk about human health and, especially, self-health, it's clear to me that the words "smoking" and "health" stand in stark and utter contradiction to each other ... inconceivable ... incomprehensible and, yes, indefensible.

And yet, every day, in every part of the world, smoking is defended. More than that: It is openly encouraged, promoted, marketed, and merchandised – often in the name of economics and more often – and more sadly – in the name of some perverse pursuit of individual freedom, happiness, success, sophistication, glamour or maturity. North American tobacco companies alone spent more than US$ 32 billion dollars last year just in advertising! Even governments that discourage smoking among their own citizens support the export of tobacco products to other countries!

The most grotesque juxtaposition, however, comes when the word "children" is added. Together, "health, smoking, and children" form the ultimate contradiction. I come before you today to plead the special cause of the world's children, that one-quarter of the earth's population who have a

WHO AT THE NINTH WORLD CONFERENCE ON TOBACCO AND HEALTH

WORKSHOPS PROMOTE THE DEVELOPMENT OF SKILLS IN THE EPIDEMIOLOGICAL SURVEILLANCE OF THE TOBACCO EPIDEMIC

Workshop on epidemiological surveillance

Reliable, timely and locally relevant data and information on a population's tobacco epidemic is vital for promoting and guiding appropriate tobacco control strategies and policies. Data are required on a variety of indicators relating to tobacco consumption, prevalence, health effects and tobacco control measures. Furthermore, these data need to be as disaggregated as much as possible in order to target the policy response to those subgroups of the population (e.g. manual workers, teenage girls) among whom tobacco use is most widespread.

In order to enhance skills in data collection and analysis, the World Health Organization convened a series of five simultaneous workshops at the Paris Conference in the context of a broader Policy Symposium on Assessing the Magnitude of the Pandemic. Epidemiological surveillance of the tobacco epidemic can be thought of as taking place at three broad levels, as shown in ***Table 1***. Thus data need to be collected on *input* variables (prevalence, consumption, etc.), as well as on disease outcome (*output* variables). If resources are available, local population studies (prospective or case-control epidemiological studies) to assess the evolution of the risks of tobacco use are both scientifically useful and politically valuable. The need for surveillance systems to encompass variables of relevance at different stages of the epidemic arises from the fact that the full health effects of tobacco use only become evident after several decades.

The purpose of these workshops was to promote the development of skills in the epidemiological surveillance of the tobacco epidemic. There are very different techniques, data sources and methodological problems associated with these different outcome measures. Equally importantly, the resources, capabilities and objectives of epidemiological surveillance will vary from one country to another, depending on the level of health and economic development.

There is, therefore, no universal set of recommendations for monitoring the tobacco epidemic. Rather, the five workshops each addressed a different aspect of assessing the pandemic, assuming very different resources and skills available to do so. In each case, the workshop followed a common format, namely a presentation on specific epidemiological methods and approaches, followed by an open group discussion of experiences, problems and suggestions for obtaining valid data on the specific topic.

Workshop 1: Rapid assessment of tobacco consumption and prevalence

This workshop was intended for those participants (primarily from developing countries), who have limited resources for assessing prevalence and consumption and where the infrastructure for routine monitoring (i.e. an adequate sample frame) is not readily available. Basic methods, approaches, problems and data interpretation were discussed.

Workshop 2: Monitoring tobacco use in statistically advanced environments

This workshop also focused on monitoring tobacco use, but here the emphasis was on the use of non-traditional approaches to data collection (e.g. telephone interviews), experience with different definitions, how to adjust for biases in data, the need for monitoring population subgroups and experience with surveys of both the general population and specific subgroups (e.g. physicians, teachers, youth). This workshop was intended for scientists from countries with more experience and capabilities for epidemiological surveillance.

Table 1

Epidemiological Surveillance of the Tobacco Epidemic

Stage of Epidemic	Examples of Variables or Methods for Data Collection or Estimation
Population Exposure	• Prevalence (age/sex/socioeconomic status) • Consumption (number/weight/tar-nicotine content) • Parameters (age at initiation/degree of inhalation, etc.)
⇓	
Process	• Prospective/case-control studies of mortality smokers vs non-smokers, by cause of death • Relative/attributable risk
⇓	
Health Effects	• Mortality/morbidity (age/sex/cause)

Workshop 3:
Using prospective studies to monitor tobacco-attributable mortality in developing countries

Prospective studies, similar to those carried out in more developed countries, are among the best methods to adequately assess mortality from tobacco in the presence of specific epidemiological environments (i.e. presence and distribution of confounding factors), and to monitor the evolution of the epidemic. The objectives, experiences, results and difficulties with one such study were discussed in detail and strategies for coordinating a global network of such studies were presented.

Workshop 4:
Exploitation of routine data sources to estimate tobacco-attributable mortality and morbidity

Mortality, and to a lesser extent, morbidity data, which are often incomplete and unreliable, are nonetheless available for many populations in the developing world where tobacco use is common. This workshop presented experiences with the use of such data (e.g. vital registration, sentinel surveillance, hospital statistics) for monitoring the health effects of tobacco use. Particular attention was given to the problem of adjusting for biases in the data and to the interpretation of trends. This workshop was intended for scientists in both developed and developing countries who have access to some source of valid, population-level health statistics.

Workshop 5:
Assessing and monitoring the tobacco epidemic: A case study

This workshop had a somewhat different objective to the others. Through the detailed presentation of a single case study, participants were informed of how data and information can be assembled and used to monitor changes in a country's tobacco or health situation, and to guide and evaluate policies designed to control tobacco use. Issues in the collection, consolidation and interpretation of data for policy and programme purposes were discussed.

MONITORING THE HEALTH EFFECTS OF TOBACCO USE IN DEVELOPING COUNTRIES

For the past three years, WHO has been working closely with the University of Oxford in the United Kingdom to establish a network of epidemiological studies to monitor the evolving health hazards of tobacco use in developing countries. Much is known about smoking-related risks in developed countries but little is known about these risks in developing countries. In order to ensure that studies are designed, conducted and analysed according to standard principles and procedures, WHO has commenced a long-term collaboration with the Clinical Trials Service and Epidemiological Studies Unit at the University of Oxford (Directors: Professor R. Peto and Dr R. Collins), and has recently designated the Unit as a WHO Collaborating Centre.

The first meeting of this network took place in Paris on 11 October 1994 in conjunction with the Ninth World Conference on Tobacco and Health. About 30 scientists from 15 countries where large prospective studies are being carried out, or being piloted, attended the workshop. The principal objectives of the meeting were:

1. to review the several large prospective studies of smoking and death that already exist, or are already being planned, in various populations around the world;
2. for populations that are not already covered by properly funded prospective studies, but where such studies might well be appropriate, to foster the establishment (and financial support) of new prospective studies that would, over the next five, ten, fifteen or more years, help monitor the local evolution of the epidemic.

The response to this initiative was very encouraging. There was unanimous agreement that this was a very important initiative in which all scientists who were present have agreed to participate. Several benefits of such collaboration were recognized. Firstly, a collaborative framework will ensure that uniform, comparable procedures for data collection, follow-up and analysis are used and hence results can be compared across countries. This will greatly facilitate global and regional assessments of the emerging health hazards of tobacco use in developing countries. It is intended that the progress of each study be reported in a monograph to be published every five years, with the first monograph to appear in the year 2000. The network will meet on the occasion of each World Conference on Tobacco and Health, with the next meeting to be held in Beijing in 1997. Meanwhile, WHO and the Oxford Collaborating Centre will continue to provide technical support to studies as requested.

WHO'S DIRECTOR-GENERAL ADDRESSES THE NINTH WORLD CONFERENCE ON TOBACCO AND HEALTH ON THE ROLE OF POLITICIANS

A highlight of the Ninth World Conference on Tobacco and Health was a special round table on the role of politicians in developing tobacco control strategies. In addition to a number of distinguished scientists who presented their views on this subject, health ministers from France, Malaysia, Norway, Sweden and Thailand also offered their views and then participated in a lively question and answer session led by British journalist, Peter Taylor, author of an analysis of political and corporate power of the tobacco industry, *The Smoke Ring*. Dr Hiroshi Nakajima, Director-General of WHO introduced the debate by succinctly posing the problem that politicians face when they attempt to promote legislation and regulation affecting tobacco products. He pointed out that the basic problem health ministers face is they often do not have the support of their ministerial colleagues for anti-smoking measures or regulations. He went on to point out, "If they do not have the support of their colleagues within government, ministers of health find themselves isolated and their action is stymied. They are under attack from both their natural enemies in the tobacco industry and from the health professionals and consumers who ought to be their defenders and allies. Health ministers are often tempted in such circumstances to give their anti-smoking campaign a lower priority. They accept the status quo and adopt a wait-and-see policy: as a result, the smoking epidemic escalates and so do the morbidity and mortality that tobacco use causes."

But Dr Nakajima also recognized that there was a solution to this problem. He said, "Fortunately many countries have managed to break this disastrous downward spiral. They have recognized that an effective anti-smoking policy must be multisectoral, involving all ministers and all areas of activity, with the support and involvement of the public and the media."

He went on to point out, "It is important that society at large and the voluntary anti-smoking movements should recognize the importance of a multisectoral approach and join in. A first step would be for them to set up a multisectoral agency at the national level to coordinate all their anti-smoking activities. It would also be helpful if they would endeavour to strengthen the position of the ministry of health, instead of weakening it by adding to opponents' criticisms. There is a need to look for the objective reasons, which are often external, for the apparent inaction of the minister of health. Why not act instead on these external factors and thus provide the minister with effective aid and constructive suggestions?"

Subsequent discussion by both scientists and health ministers confirmed Dr Nakajima's view of the fundamental importance of adopting a multisectoral approach as the key to the successful implementation of effective tobacco control policies.

NEWS BRIEF

CHINA TO HOST THE TENTH WORLD CONFERENCE ON TOBACCO AND HEALTH BEIJING, 24–28 AUGUST 1997

China has been selected to host the Tenth World Conference on Tobacco and Health in 1997, the theme of which will be: ***Tobacco: The growing epidemic***

WHO will provide technical support to the organizers of this important activity and will make every effort to ensure its success.

As it is the first such conference to be held in a developing Asian country, it is of special significance. It will not only produce a great impact on health education and tobacco control in China, but will also have a positive health effect in Asia and the world.

EVALUATION OF TOBACCO CONTROL PROGRAMMES AND POLICIES: PURPOSE, PROCESS AND PRIORITIES

Introduction

Despite the tremendous human and financial impact of tobacco-related diseases, it is unfortunately still true that tobacco control activities are seen as both financially and socially costly and that doubts about their effectiveness are expressed. Therefore, the evaluation of the impact, efficiency and effectiveness of such activities is essential to justify tobacco control programmes and policies.

Within this context, WHO is publishing a monograph entitled *Evaluating tobacco control: Experiences and guiding principles*, which is the first reference text to bring together in a single work an overview and evaluation of all the major tobacco control measures that have been adopted by countries.

Purpose and limits of evaluating tobacco policies and programmes

The purpose of evaluation is to improve tobacco control programmes, guide current and future programmes and convince sceptics. Tobacco control activities have special, behavioural, political and economic aspects. This fact makes it more important to determine if the outcomes were due to the actions undertaken or to external factors.

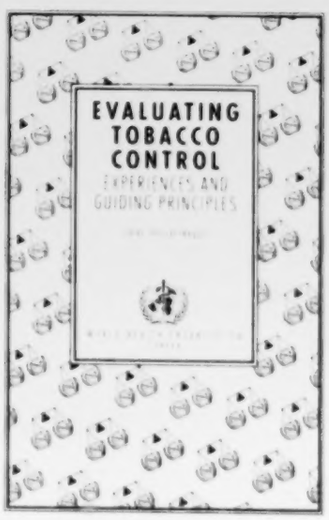
There is a huge difference between evaluating the effectiveness of a tobacco control activity at the micro-level (for example, the effect of tobacco-free workplace measures in a factory) and at the macro-level (for example, national bans on smoking in public areas). Macro-evaluation should never be the sum of a series of micro-evaluations, as a number of secular changes (prices, taxes and different types of economy of scale), as well as local psycho-behavioural factors, can strongly affect the micro level.

Another limit of evaluating tobacco policy is that the final impact (avoiding deaths) can only be measured after a relatively long period of time. Therefore, evaluation is often made on the basis of intermediate results such as improved knowledge of the risks of tobacco use or reduction in the prevalence of tobacco use.

Process and management of evaluation

The process of evaluation encompasses the following main themes: 1) specifying the subject of evaluation; 2) ensuring information support; 3) verifying relevance; 4) assessing adequacy; 5) efficiency; 6) effectiveness; 7) impact; 8) reviewing progress and drawing conclusions and formulating proposals for future action.

The process of evaluation should be used in a flexible manner



and adapted to the circumstances of the evaluation.

Clearly ***specifying the particular subject*** for evaluation is essential to the good management of the process. Getting the right mix of activities in response to various political, economic, social and cultural situations, requires that the question "How useful is this measure to control tobacco here and now?" be answered.

Relevance relates to the importance of tobacco control policies. Relevance evaluation will include testing the continuous validity of the programme in terms of essential human needs and priorities in the field.

Evaluation of ***adequacy*** will determine whether sufficient attention has been paid to the development of objectives, targets and methods in relation to the operational context. For example, school health education programmes would only be recommended in an environment where all children are attending school.

Efficiency is an expression of the relationship between the results obtained and the efforts expended in terms of human, financial and other resources. Efficiency assessments are aimed at improving implementation and add the progress reviews which facilitate the control of ongoing activities. Measuring the efficiency of a programme should also include a review of equity in its distribution. For example, if the programme is for a total population, have its benefits been properly distributed to the total population?

Effectiveness is an expression of the desired effect of the programme, service or activity in reducing tobacco consumption. Whenever feasible, the effects should be quantified. Where this is not feasible, a qualitative analysis of the relevance and usefulness of the achievement should be performed. The evaluation of effectiveness should also be an assessment of the satisfaction or dissatisfaction expressed by the community concerned regarding the effects of the programme or service.

In managing evaluation activities it is important to involve all those concerned in the policy or programme in the process. The principle that evaluation should be conducted as an integral part of the development and implementation of programmes implies that those responsible for implementation, on whatever level, should also be responsible for evaluation. Therefore, the selection of the evaluation team is crucial to the management of evaluation.

Priorities, timing and cost of evaluation

It is difficult to make a recommendation on the amount of resources (financial and otherwise) to be spent on evaluation. Evaluation is least costly whenever undertaken as an integrated part of a managerial process.

Closely linked to the issue of cost is the problem of timing and frequency of evaluation. While evaluation should be a continuous process in tobacco control it will be necessary to take stock of the effectiveness of the programme and their impact on a longer time-span.

Advantages of standardized definitions and methodology

The ultimate outcome demonstrating the success of tobacco control programmes is a reduction in tobacco attributable deaths and diseases through a reduction in tobacco consumption. Two difficulties often arise in the measurement of outcome. The first problem is the lag in the occurrence of attributable mortality and morbidity and the second difficulty is to disentangle the individual effects of the many simultaneously implemented programme components. Intermediate outcomes, may thus be necessary to evaluate the specific merits of individual components of such multi-component programmes.

There is a significant value in employing standardized definitions and methodology to evaluate the outcome of programmes. Standard conceptual frameworks will promote comparability across studies and also facilitate the replication of programmes and the estimation of their relative cost efficiency. WHO has been issuing norms and questionnaires to support efforts to this effect.

Complete standardization, however, is not always possible and methods of intervention may face obstacles in a number of developing countries. For this reason, WHO places emphasis on defining indicators which are valid for both developed and developing countries.

Conclusion

The art of evaluation is to be able to give the right judgement which should lead to drawing sensible conclusions and making useful proposals for future action. In light of the continuing need to provide strong justification for tobacco control programmes, WHO is issuing a monograph on experiences and guiding principles of tobacco control evaluation. The three key questions which must always be answered to get an appropriate evaluation are: What outcomes of the programme need to be checked? Where should information for the evaluation be found and what kind of studies should be conducted? What methods should be selected for evaluating the programme? It is thereby the hope of WHO to encourage tobacco control activists and legislators to emulate the numerous examples contained in the monograph, which demonstrate the progressive and worldwide success of the tobacco control movement.

James Grant... cont'd from pg. 2

unique vulnerability to the effects, lure, and license of tobacco's uses — and to the enticing messages of tobacco's promoters.

Eighteen months ago, at UN headquarters in New York, the children of the world were the subject of an extraordinary World Summit — the first of the post-Cold War era, and the first ever of leaders of North, South, East, and West. Children's needs, their rights, and their critical importance to our collective future were all affirmed by 71 heads of state and government, plus senior representatives of another 88 countries, who put their signatures to a Declaration and Plan of Action committing themselves and their governments to the achievement of 27 specific and measurable goals within strict time limits. This is an unprecedented social action programme to be carried out on a global scale, and present trends on smoking work against it in many parts of the world.

Given the harmful effects of smoking on fetuses and children, and on families as a whole, any significant reduction in smoking would contribute to reaching several of our goals for children by the end of the decade.

Programmes that help young people to make the healthy choice against the smoking habit are critical because the overwhelming majority of new smokers embark on their addiction (and it is demonstrably an *addiction*) before they are out of their teens. Young people, understandably, are in a hurry to be viewed as adults, and smoking has for many decades been promoted as a sophisticated, "adult" activity. Cigarette promoters have been quick to make the deadly connection with youth.

Young people between the ages of 10 and 24, representing one-third of the world's peoples and growing 50 per cent faster than the earth's total population, are highly susceptible to the myriad messages communicated in words and deeds by society, by governments, by peers, by private sector businesses — indeed, by the very culture in which these young people grow up and form the habits of a lifetime. Where better, then, to begin such an indelible, triumphant crusade against tobacco — a crusade that could literally eliminate the menace of smoking within a generation?

Excerpts of a presentation by ***James Grant*** *at the Eighth World Conference on Tobacco or Health, Buenos Aires, 1992*

METHODS OF MEASURING THE EFFECTIVENESS OF A PROGRAMME

This session at the Ninth World Conference on Tobacco and Health was chaired by Dr Annie Sasco of the International Agency for Research on Cancer (IARC) and the National Institute of Health and Medical Research in Lyon, and Professor Jean-Pierre Gérard, Dean of the Faculty of Medicine at the University of Lyon-Sud. The choice of speakers was guided by concern to demonstrate the universality of this problem, irrespective of the predominant culture, prevailing political system and nature of the medical and health environment. Demonstration of the effectiveness of a prevention programme depends on a rigorous procedure for evaluation. This word is in fashion, for better or for worse! For decades now, it has been the norm for any conscientious clinician only to use treatments that have been rigorously evaluated, in the vast majority of cases, by randomized double blind therapeutic trials. But what is now accepted by all in the field of curative medicine has not yet taken root very deeply in the minds of those involved in prevention. Naturally, the constraints, and particularly the financial constraints, that apply to all public health professionals have made the word "evaluation" more or less obligatory in all project submissions, although workers in the field are not yet convinced of the real benefits that well-conducted evaluation can bring to their action.

Professor Pekka Puska, of the National Institute of Public Health in Helsinki, Finland, presented the remarkable health education programme that has been under way in North Karelia since 1972. This part of Finland, characterized by high cardiovascular mortality, embarked on a vast programme in the 1970s to control smoking and modify dietary habits. After a period of intense activity at the outset, fresh initiatives were introduced in the 1990s. Regular checks on smoking, using both questionnaires and biological markers, have helped to monitor the impact of this programme in areas of action and control areas for comparison. Smoking, especially among men, has declined sharply in North Karelia, as well as in Finland generally.

Dr Gemma Gatta, of the Cancer Institute in Milan, Italy, has evaluated the impact of various smoking prevention strategies among children and young people. No difference was found in rates of smoking among children aged 9 to 10 years after a brief information intervention, but a programme to modify attitudes and behaviour among adolescents of 12 to 13 years did bear some fruit. This demonstration, based on a strict methodology with random selection of an action group and a control group, will enable the health authorities to choose the measures they wish to adopt.

Dr Paul Wangai, of Nairobi, Kenya, stressed the need for evaluation methodology to be both sound and rigorous in order to permit international comparisons, while at the same time being sufficiently flexible to be adapted to the culture of each intervention locality. The situation of smoking control in Africa exactly illustrates this concept.

Professor Guy Parcel, of the Centre for Health Promotion Research and Development at the School of Public Health of the University of Texas at Houston, USA, emphasized the importance for increasing the potential impact of actions to prevent smoking among young people of having, on the one hand, programmes capable of modifying the determinants of smoking, and on the other hand, of reaching a substantial proportion of the target population. So far, too little attention has been paid to methods of intervention for adapting and implementing programmes of prevention. The example selected is the "Smart choices" project to determine the sensitivity of teachers and the administration to a smoking prevention programme, measures for the adoption of the programme, levels of effective implementation and continuation of the programme, exposure of schoolchildren to the programme, and, lastly, its impact on their behaviour.

SYMPOSIUM: DEVELOPING POLICY AND FINDING FUNDS

A highlight of the Ninth World Conference on Tobacco and Health was a Policy Symposium entitled "Developing Policy and Finding Funds". The symposium was divided into two parts. The first ninety minutes were devoted to overview presentations on the practical issues of tobacco policy development and funding. Participants then split up into five simultaneous workshops to examine particular topics more intensively.

Presenters in the main session brought the clear message that there are recent examples of apparent success in developing well-funded, comprehensive tobacco control policies. Outstanding examples of these from three countries – Canada, Australia and France – were presented. In Canada, where comprehensive tobacco control policies were gradually introduced throughout the 1980s, per capita adult cigarette consumption fell by 37% from 1981 to 1992. In Australia, the creation of Health Promotion Foundations, funded by tobacco taxes – in effect, taxing harm to improve health – has resulted in a wide variety of improved health promotion programmes in Australia, and markedly reduced tobacco consumption. In France, which implemented comprehensive tobacco control policies in 1993, there are already early indications of some success with the new policy. Overall, smoking prevalence declined from 1992 to 1994 by about two percentage points. Encouragingly, declines were observed for adults and adolescents of both sexes.

There has also been success in raising funds for tobacco control activities in all three of these countries. There has been long experience in the state of Victoria, Australia with the use of a dedicated levy on tobacco to fund a Health Promotion Foundation. France similarly used a time-limited tobacco tax to replace tobacco sponsorship of major motor sports events with health sponsorship. In Canada, major new funding has been introduced for a national Tobacco Demand Reduction Strategy. The money has been awarded for a three-year period through regular government budgetary allocation procedures. This expenditure, however, is offset by a new three-year surtax on tobacco company profits that is expected to yield an amount of tax approximately equal to the new expenditure on the Tobacco Demand Reduction Strategy. These successful financing schemes vary in their details, but all use new tobacco taxes to fund tobacco control and health promotion, or, in one case, to balance the cost of new tobacco control initiatives. In the long run, self-financing schemes that use the problem to create the solution appear to be the best options for funding tobacco control activities.

However, success has not been achieved in these countries without considerable effort. Other speakers stressed the importance of good organization, careful planning and complete mastery of all relevant policy information as the keys to the development of successful, well-funded tobacco control policies.

The focus then shifted to five simultaneous workshops. Again, regardless of the workshop topic, strong themes to emerge were that good organization, careful planning, results-oriented pragmatic management and complete mastery of all relevant policy information were needed if objectives were to be successfully achieved.

A workshop on tobacco control in Islamic societies resolved to create an Islamic Council for Tobacco Control, a resolution that was subsequently adopted by the Conference as a whole. In another workshop, participants recognized that even with little or no money at all, effective tobacco control was still possible. Reports were given on successful community tobacco control programmes that have been operating with little or no funding in Sri Lanka and Bangladesh. A third workshop stressed that strategic management was the key to successfully obtaining and administering budgets for tobacco control. In a fourth workshop on the subject of dealing with tobacco company opposition to tobacco control policies, coalition-building, good management and solid funding emerged as keys to success. The fifth and final workshop on the role of civil servants in tobacco control revealed that civil servants do have a key role to play in developing tobacco control policies and that, like everyone else, they will be more likely to succeed if their work is carefully planned, well-managed, strategic and has strong and broadly-based support.

The clear conclusion from the symposium was that the keys to success in tobacco control policy development and funding are much as they are in many other endeavours – good organization, careful planning, results-oriented strategic management and mastery of all relevant information. It is to be hoped that valuable lessons learned from this symposium will be applied in jurisdictions where strengthened tobacco control policies are being contemplated.

WHO/REGIONAL OFFICE FOR THE WESTERN PACIFIC

ACTION PLAN ON TOBACCO OR HEALTH FOR THE WESTERN PACIFIC 1995–1999

The tobacco industry has predicted sales increases in Asia of 33% between 1991 and the year 2000. Tobacco consumption in the region increased by 15% between 1988 and 1992.

Countries and areas which had taken significant action prior to the commencement of the 1990–1994 action plan have strengthened their activities and implemented further important measures. Many countries and areas which had not taken significant action prior to 1990 have now implemented national action. The majority of countries and areas have now established a national focal point on tobacco or health, and also celebrate World No-Tobacco Day on 31 May each year.

Action plan on tobacco or health for 1995–1999

The action plan on tobacco or health for 1995–1999 calls for all governments to implement comprehensive tobacco control measures by 1999. These include a national policy and a central coordinating agency on tobacco or health; health education; comprehensive tobacco control legislation; and pricing policy. Highlights include:

- a call for a "Tobacco-advertising-free Region by the Year 2000" as part of comprehensive legislation on tobacco or health;
- the recommendation that a percentage of tobacco tax should be used to fund sports, arts and health promotion, so that sports and arts organizations do not suffer from the ban on tobacco sponsorship;
- introduction of health information and advocacy on tobacco or health into medical curricula;
- compliance with the International Civil Aviation Organization resolution that all airlines become smoke-free by 1996;
- involvement of religious and other community groups in tobacco or health activities;
- the goal, for countries and areas with a long history of tobacco or health action, to decrease their tobacco consumption by at least 1–2% per year;
- the goal, for countries and areas that had not previously taken significant action on tobacco or health, to implement national action (with a view to reducing consumption during the next 2000–2004 action plan on tobacco or health); and
- the goal, for all countries and areas, to prevent rises in smoking among women.

CANADIAN INTERNATIONAL DEVELOPMENT RESEARCH CENTRE ANNOUNCES INTERNATIONAL INITIATIVE FOR TOBACCO POLICY RESEARCH AT THE NINTH WORLD CONFERENCE ON TOBACCO AND HEALTH

An exciting new funding initiative for tobacco policy research was announced by representatives of the International Development Research Centre (IDRC) at the October, 1994 Ninth World Conference on Tobacco and Health. IDRC has created an International Initiative for Tobacco Policy Research for developing countries. The initiative is funded by IDRC and Canada's Ministry of Health. This initiative will provide both a funding and knowledge base for policy relevant research, capacity building, and information for dissemination in support of effective tobacco control in developing countries. It will have initial resources of US $1.5 million.

In many developing countries, the lack of research, resources and capacity in the tobacco issue, combined with increased efforts of the tobacco industry, creates a fertile climate for trends towards higher rates of tobacco consumption and production. Many developed countries have demonstrated that successful measures to reduce tobacco use depend upon comprehensive and consistent public policy, underpinned by multidisciplinary research.

The funds for this initiative will be available for strategic research towards public health policy in social, economic, agricultural, environmental, international trade and health sectors. It holds potential to further enhance networking among tobacco control practitioners, both in developed and developing countries.

Persons interested in learning more about the International Initiative for Tobacco Policy Research or applying for project funds should contact:

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Editorial... cont'd from pg. 1

dred thousand million dollars. This is a very large sum of money. If it could be harnessed it would be sufficient to double present health care expenditure in all the developing countries.

But can public health win its fight against tobacco? Yes, I am convinced we can win, indeed, for the sake of everyone's health, we **must** win. I have no illusions and I am sure you don't either: very considerable forces are arrayed on the side of smoking and against public health, and they are making and will continue to make progress difficult.

However, let us not forget that public health too can mobilize a formidable coalition in its support. Local and national community movements, and international nongovernmental organizations are working alongside WHO to support governments and encourage them to step up the fight against smoking. The five major international nongovernmental organizations under whose auspices this conference is being held, along with WHO, have played a considerable role in slowing down and sometimes reversing tobacco consumption.

Tobacco is a commodity in international trade. ***The fight against tobacco must therefore be worldwide. It must be based on a concerted global strategy, on well-coordinated action.***

I am proud of what WHO has been able to achieve in the fight against smoking. I am also aware of and grateful for the assistance we have been given. It is thanks to the resources that you have all placed at our disposal that we have been able to lead the worldwide effort against smoking. To control the epidemic we first needed to measure its dimensions. We have improved worldwide surveillance of the epidemic, providing reliable estimates of the prevalence of smoking and of the mortality that smoking causes.

Our work in collaboration with other United Nations agencies and other international organizations is also bearing fruit. The World Bank no longer grants loans for projects linked to the growing or manufacture of tobacco. The International Civil Aviation Organization has adopted a resolution calling for a ban on smoking on all international flights by 1 July 1996. Already a number of airlines are offering non-smoking flights. This is in response not only to a concern for public health but also to the demand from customers, more and more of whom are calling for totally smoke-free flights.

Several United Nations agencies now provide their staff with a smoke-free environment. I am confident that others will soon join us to give their employees more protection against passive smoking. At the request of the Economic and Social Council, ***the Secretary-General of the United Nations has just set up a liaison body within the United Nations Conference on Trade and Development, in co-ordination with WHO.*** This body is responsible for promoting intersectoral collaboration between the various United Nations agencies and any other external organization concerned with the social and economic aspects of tobacco, in order to ensure that the very serious consequences of smoking on health for all are taken into account.

It is for the new generations, and with them, that we must win the battle. Early dependence is the strongest. Those who are trying to sustain the tobacco market because of the financial rewards are well aware of this. Already, throughout the world, they are sparing no effort to create dependence on their dangerous products among the very young. This needs to be made known and we must have the courage to say it. ***Higher tobacco sales mean greater and more widespread dependence, greater risks of premature death, and a heavier financial burden for individuals and society.***

And what do those of us who work for public health have to offer? We can reward our children and our grandchildren with long, happy and healthy lives. Lives free from tobacco, from dependence and from the accompanying risk of early death. I make a solemn appeal to all Member States of the World Health Organization to provide us with the means to give our children this present of life and hope.

NEWS BRIEF

US FEDERAL AGENCY FOR HEALTH CARE POLICY AND RESEARCH

The US Federal Agency for Health Care Policy and Research (AHCPR) has formed a private-sector panel of health-care experts and consumers to develop a clinical practice guideline to improve the effectiveness of smoking prevention and cessation programme.

The Centers for Disease Control and Prevention (CDC) is co-funding the project. (AHCPR and CDC are agencies of the Public Health Service, US Department of Health and Human Services.)

WHO/TOH PROGRAMME

TWO NEW WHO COLLABORATING CENTRES ESTABLISHED

New WHO Collaborating Centres are being established in the Clinical Trials Service and Epidemiological Studies Unit, University of Oxford, United Kingdom and the Department of Cancer Control and Epidemiology of the Maria Sklodowska-Curie Memorial Cancer Centre and Institute of Oncology, Warsaw, Poland. The former, the WHO Collaborating Centre for Chronic Disease Control, is under the direction of Professors Richard Peto and Rory Collins, while the latter, the WHO Collaborating Centre on the Action Plan for a Tobacco-free Europe, is directed by Dr Witold Zatonski.

Both Centres have wasted no time in getting on with the serious business of collaborating with WHO to help document and eventually control the tobacco pandemic. The University of Oxford's Clinical Trial Service Unit and Epidemiological Studies Unit have collaborated with WHO and epidemiologists from the American Cancer Society, to produce a landmark 550-page reference text that documents in great detail the number of deaths caused by smoking in all developed countries. The new UK WHO Collaborating Centre organized a major news conference on 20 September 1994 to announce the release of the book

and highlight its major findings. The report reveals for the first time how many millions of victims tobacco has already claimed:

> ***"In developed countries, death from tobacco is already the biggest epidemic that the World Health Organization is faced with. Between 1950 and 2000, tobacco will have killed about 60 million people in developed countries alone. About 40 million will have been killed while still only in middle age (35–69). On average, those killed by tobacco in middle age lose more than 20 years of life expectancy."***

The report goes on to document that the tobacco epidemic is currently at its worst in Central and Eastern Europe.

The WHO Collaborating Centre on the Action Plan for a Smoke-Free Europe will concentrate on strengthening tobacco control in Central and Eastern Europe. The official opening of the Collaborating Centre was held in Warsaw on 5 October 1994 and was followed by a Workshop on Tobacco Control Programmes. Invited participants from the United States, Canada and many countries of Central and Eastern Europe met to trade ideas and experiences on how to implement comprehensive tobacco control programmes throughout Central and Eastern Europe. It was pointed out at a news conference that 42% of all Polish male deaths in middle age were caused by tobacco – more than in any other country.

Both new WHO Collaborating Centres have had auspicious beginnings. It is hoped that their early successes will be followed by many more. It is anticipated the WHO Collaborating Centre on Chronic Disease Control will concentrate on monitoring the evolution of the tobacco epidemic in developing countries, while the WHO Collaborating Centre on the Action Plan for a Tobacco-Free Europe will be sparing no effort to help and encourage the countries of Central and Eastern Europe to implement the Action Plan for which the centre was named.